From April 2013, pre-procedural USS was carried out on each patient attending for SPC insertion. Patients with overlying bowel were referred for open insertion.
Result: 322 SPCs were inserted between July 2008 – April 2013 without the routine use of pre-procedural USS. 101 were inserted between May 2013- June 2015 with USS guidance.
Following the introduction of USS, there were no recorded cases of bowel perforation associated with SPC insertion (Without USS 3/322, 0.9%, with USS 0/101, 0%). Referrals for open insertion increased (Without USS 7/322 (2.6%), with USS 12/101 (12%)).
Conclusion: In our clinic, use of pre-procedural USS has eliminated the risk of associated bowel perforation, with an appropriate increase in referrals for open insertion.
Dedicated SPC clinics provide a safe and effective service for SPC insertion with excellent opportunities for training.

http://dx.doi.org/10.1016/j.ijsu.2016.08.472

0962: IS THERE A ROLE FOR ORCHIDECTOMY IN THE MANAGEMENT OF REFRACTORY CHRONIC TESTICULAR PAIN

H. Garrod*, G. Brown. *Royal Glamorgan Hospital, Llantrisant, UK.*

Aim: Chronic testicular pain represents a difficult challenge for the urologist and has a varied aetiology. Around 25% of patients will not have a cause identified for their symptoms but continue to experience debilitating pain. When pain is refractory to pharmaceutical treatment, patients may be referred for consideration of orchidectomy. We aim to assess the effectiveness of this procedure.
Method: Eight patients who underwent an orchidectomy for chronic testicular pain were retrospectively reviewed. A telephone follow-up was conducted to assess post-operative pain outcomes.
Result: Average age was 44 years. 88 % said their pain improved, 62 % reorted complete resolution. The mean improvement in all patients was 65%. Only one patient felt there had been no improvement in their pain. There was no consistent singular histological finding although half of patients showed evidence of fibrosis or atrophy. One patient felt that their pain had not improved and felt there had been additional sexual and psychological problems that outweighed the benefits of surgery.
Conclusion: This study supports other data that orchidectomy is an effective treatment in refractory chronic testicular pain. Careful patient selection is paramount and further research is required to identify patients most likely to benefit from this procedure.

http://dx.doi.org/10.1016/j.ijsu.2016.08.473

0970: SURGICAL OUTCOME ANALYSIS OF 130 CONSECUTIVE PARTIAL NEPHRECTOMIES UNDERTAKEN IN THE SOUTH WALES REGION AND COMPARISON WITH BAUS (STUKA) DATA

D. Teichmann[1,*], L. Whitehurst[1], R. Chaytor[2], I.l Omar[3], O. Naser[3], M. Kamarizan[4], A. Carter[4], S. Moosa[3], K. Narahari[1], R. Coulthard[1], N. Fenn[2]. [1] *University Hospital of Wales, Cardiff, UK;* [2] *Morriston Hospital, Swansea, UK;* [3] *Glangwili General Hospital, Carmarthen, UK;* [4] *Royal Gwent Hospital, Newport, UK.*

Aim: Partial Nephrectomy is an increasingly popular technique for managing small renal tumours both via an open and laparoscopic approach. We wished to compare our regional numbers, approaches and complication rates to the nationally published BAUS STUKA audit
Method: We performed a retrospective case-note analysis across 4 regional centres of 130 consecutive partial nephrectomies between the years of 2011-2015. We examined patient demographics, surgical approach, operation time, blood loss, warm/cold ischaemia time, tumour histology, margin positivity, length of stay and complication rates as classified by the Clavien-Dindo system (CD)
Result: Our results compare favourably with the STUKA audit in the domains of post-operative complications as classified by CD 2-5 (10% vs 13%). A lower percentage of cases are done laparoscopically (14% vs 24% nationally) despite tumour size distribution being similar. Margin positivity was similar laparoscopically (5.5%), although higher than the national average in open cases (10.7% vs 5%). Malignant disease was 6% lower (81% vs 87%) and benign disease was 7% higher (11% vs 18%). There were no patient deaths and no recorded recurrences at present.
Conclusion: We believe this practice evaluation provides the foundation for service development. Varied numbers between units favour centralisation of care thus allowing development in laparoscopic techniques including the recently acquired robotic service.

http://dx.doi.org/10.1016/j.ijsu.2016.08.474

1039: SHOULD WE RECONSIDER RUSHING TO CONVERT NEPHROSTOMIES TO ANTEGRADE STENTS IN THE PALLIATIVE SETTING?

L. Chandra*, P. Hughes, M. Kimuli. *Leeds Teaching Hospitals Trust, West Yorkshire, UK.*

Introduction: The management of ureteric obstruction in the palliative care setting is potentially challenging. Clinicians often deliberate long and hard with patients and family regarding the implications of their prognosis and the role of nephrostomies in alleviating renal failure. However, subsequent conversion to an antegrade stent is often regarded as a default procedure, but perhaps may not always appropriate for patients with very limited lifespans.
Method: We performed a retrospective review of all antegrade stents inserted (2011-14) as a consequence of malignancy within our institution. Demographics, primary malignancy, disease stage and treatments to date were detailed along with survival duration post stent insertion.
Result: 73.5% of patients receiving 'best supportive care' died within 90 days of antegrade stent insertion. For patients receiving curative or palliative treatment this was only 12.5% and 21% respectively.
Conclusion: Recognising the limited lifespan that patients considered for best supportive care have, clinicians should consider the need and appropriateness of a second invasive procedure to insert an antegrade stent. This study can help influence quality of life discussions with patients who face the final phases of their lives.

http://dx.doi.org/10.1016/j.ijsu.2016.08.475

1163: THE INTRODUCTION OF MULTIPARAMETRIC MRI IN PROSTATE CANCER MANAGEMENT: DOES IT AID THE UROLOGIST?

D. Loughran*, D. Teichmann, P. Bose, J. Featherstone, S. Davies, R. Evans, N. Fenn. *Morriston Hospital, Swansea, UK.*

Aim: NICE prostate cancer guidelines recommend the use of multi-parametric MRI in patients undergoing i) active surveillance or ii) those with a raised PSA wishing to avoid initial or repeat biopsy. We examine management outcomes in these groups following the introduction of our new 3T mpMRI Service.
Method: Patients were categorised as either; being on or considered for Active Surveillance (n=29), or patients being investigated for a raised PSA, either biopsy naïve (n=11) or with previous biopsies (n=13).
Result: In the 'active surveillance' group, mpMRI allowed 83% (n=24) to be reassured of low volume disease with 10% (n=3) requiring further investigation with a targeted biopsy (7%, n=2) or bone scan (3%, n=1) Two patients underwent definitive management in the form of EBRT and recruitment to a HIFU trial.
In the 'biopsy naive' group (n=11), 10 were reassured and 1 underwent targeted biopsy.
In the 'previous biopsy group' (n=13), 10 were reassured, 2 underwent targeted biopsy, the last was inconclusive due to THR's.
Conclusion: Adoption of NICE guidance on mpMRI indications allowed evidence based decisions to be made regarding maintenance of AS, prevention or initiation of targeted biopsy, or active treatment.

http://dx.doi.org/10.1016/j.ijsu.2016.08.476